

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM APPLICATION

1. Please fill out your name and address

Your Name and Address

Social Security Number
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Telephone Number
() _____ (home)
() _____ (work)

2. Please complete the following information regarding your employment, or the employment of the parent whose employer offers the group health plan.

Your Employer's Name and Address

Employee Benefits Manager (if available)
Telephone Number
() _____

3. Employee's name and SSN (if different from your own) _____

4. Please complete the following information regarding your insurance. If you have more than one health plan, please list all.

Insurance Company _____	Insurance Company _____
Name of Plan _____	Insurance Company.. _____

5. Please list all persons eligible for coverage under this plan.

Name	Date of Birth	Relationship	Medicaid Covered	Applied
			yes <input type="checkbox"/> no <input type="checkbox"/>	_____
			yes <input type="checkbox"/> no <input type="checkbox"/>	_____
			yes <input type="checkbox"/> no <input type="checkbox"/>	_____
			yes <input type="checkbox"/> no <input type="checkbox"/>	_____
			yes <input type="checkbox"/> no <input type="checkbox"/>	_____

Signature: _____ **Date Completed:** _____

For DSS Use Only Case ID Number _____ New case <input type="checkbox"/> Redetermination <input type="checkbox"/>	Caseworker ID # _____ Aid Category _____ Court Ordered Absent Parent Case _____ Major Illnesses yes <input type="checkbox"/> no <input type="checkbox"/>
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